Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
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September 4, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma:

We applaud the Administration for recent efforts to reduce regulatory burden under the Centers for Medicare and Medicaid Services' (CMS) Patients over Paperwork initiative. Under the Medicare Red Tape Relief Project, a similar initiative undertaken by the Ways and Means Committee, we heard from over 100 individual post-acute care (PAC) providers across the country on unnecessary and burdensome regulations and requirements in the Medicare Program. This is a testament to the fact that there is a real opportunity to get red tape out of the way in order to drive more efficiency and promote innovation, while reducing costs and improving patient care. We write today to highlight issues presented to the Committee by PAC providers as part of the Committee's Medicare Red Tape Relief Project and urge the Administration to continue its efforts to reduce burden for providers and remove other regulatory barriers that get in the way of patient care.

According to a large survey of health systems, hospitals, and PAC providers, health systems with PAC beds devote an additional 8.1 full-time employees to compliance with PAC regulatory requirements, over half of whom are clinical staff who could otherwise be caring for patients.[1] PAC providers must comply with an estimated 288 PAC-related federal requirements, and PAC providers, health systems, and hospitals spend a combined $39 billion each year solely on the administrative activities related to just federal regulatory compliance.[2] That does not account for the numerous state and local requirements that also apply to these providers.

The following is just a sample of key issues and recommendations presented to the Committee by PAC providers as part of the Committee's Medicare Red Tape Relief Project.

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[1] American Hospital Association. Regulatory Overload Report: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers, October 2017. Accessed on July 19, 2018 at https://www.aha.org/system/files/2018-02/regulatory-overload-report.pdf

[2] *Id.*

Long-Term Care Hospital 25 Percent Rule
The Long-Term Care Hospital (LTCH) 25 percent rule is restrictive and burdensome because it sets a limit on the share of an LTCH's cases that can be admitted from referring acute care hospitals and reduces payments for LTCHs that exceed the threshold. This requirement imposes significant regulatory burden on providers while limiting beneficiary access to an appropriate level of care. We applaud CMS for permanently eliminating the 25 percent threshold policy in the FY19 final payment rule for LTCHs.

Inpatient Rehabilitation Facility Open-Door Forum
Additionally, the opportunity to learn information from and communicate with CMS on a regular basis is critical to reduce burden for providers as they adjust to ever-changing regulations and sub-regulatory guidance. Unfortunately, there is a lack of provider engagement from CMS for Inpatient Rehabilitation Facilities (IRFs) because they are the only PAC provider type without an Open-Door Forum (ODF). The Committee strongly encourages CMS to establish recurring ODFs for IRFs similar to other PAC providers to facilitate greater transparency and communication with the provider community.

Skilled Nursing Facility Consolidated Billing
Skilled Nursing Facilities (SNFs) encounter challenges related to consolidated billing. The Balanced Budget Act of 1997 (BBA '97) required that a SNF itself submit all Medicare claims for the services that its residents receive, known as consolidated billing. BBA '97 allowed for certain exclusion of care services not typically offered in a SNF to be separately paid under Medicare Part B. Over time, Congress and CMS have expanded the list of exclusions to include items and services that are not typically part of a SNF care plan. This ensures that a SNF is not required to absorb certain high-cost services and items that particular patients may need in certain circumstances. SNFs and Certified Public Accounting (CPA) firms preparing consolidated billings state that they face backlogs and contradictory CMS interpretations of excluded and non-excluded items. We urge CMS to take steps to streamline consolidated billing processing and clarify policies to reduce time lost on paperwork when such resources could instead be diverted to patient care.

Documentation to Satisfy Home Health Eligibility
We urge CMS to also take steps to reduce burdens on Home Health Agencies (HHAs). The Bipartisan Budget Act of 2018 (BBA '18) authorized Medicare to permit home health eligibility determinations to be based on the whole patient record rather than just the certifying physician's record. The Committee encourages CMS to exercise its regulatory power authorized under BBA '18 to provide that the patient records of a home health agency are considered when determining eligibility. Specifically, we appreciate CMS acknowledging in its CY 2019 Home Health Prospective Payment System proposed rule the ability for home health agencies to provide information on the plan of care that is ultimately signed by the physician. We hope CMS will work with HHAs to implement this approach and other low-burden approaches when considering the patient record for home health eligibility.

Hospice Medical Review Audits

As it relates to hospice providers, we urge CMS to increase accountability and transparency for auditors and assure that auditors are appropriately trained and educated in hospice eligibility and regulations. In addition, government auditors should ensure that medical review audits are not inappropriately duplicative among different audit contractors for patients and claims already reviewed.

In all of the above examples, PAC providers have found themselves spending more time each day on documentation and regulatory compliance, taking them away from patient care. These regulatory burdens continue to drive up the cost of care for patients with Medicare beneficiaries ultimately paying the price. We appreciate CMS' continued focus on burden reduction, and we look forward to a continued partnership with the Administration to achieve this goal.

Sincerely,

KEVIN BRADY
Chairman
Committee on Ways and Means

PETER J. ROSKAM
Chairman
Subcommittee on Health
Committee on Ways and Means

CC: The Honorable Mick Mulvaney
Director
White House Office of Management & Budget

CC: The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services